

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035952

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3425 Registrar's No. 142

FILED OCT 7 1963

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in lb <u>24 hrs</u>		Inside Limits <u>Yes</u> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains Memorial</u>		d. STREET ADDRESS (If outside, give location) <u>1135 Columbus</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Cecil Ray Trail</u>			4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/1909</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Southwest Trucking Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>George Trail</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Workman</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Ballinger Trail</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of serv <u>none</u> )		16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>Mabel Trail, West Plains, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>11:55 PM</u> a.m. <u>11:55 PM</u> p.m. <u>11:55 PM</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>Howell</u> STATE <u>Missouri</u>	

21. I attended the deceased from 11:55 PM to 10-3-63 and last saw him alive on 10-3-63  
Death occurred at 11:55 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John F. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>10-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/6/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City, town, or county) <u>West Plains, Missouri</u>	(State)
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo.</u>		25. DATE REC'D. BY LOCAL REG. <u>10-5-63</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59  
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1961 6 100

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jerry Cravens

Licensed Embalmer No. 5050

P. O. Address Thayer Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.